

		FOR OFFICE USE					

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH Facility ID Number: <u>0031831</u></p> <p>Facility Name: <u>Reservoir Manor</u></p> <p>Address: <u>419 E. Main Street</u> <u>Shelbyville</u> <u>62565</u> Number City Zip Code</p> <p>County: <u>Shelby</u></p> <p>Telephone Number: <u>(217) 774-9544</u> Fax # <u>(217) 774-9545</u></p> <p>IDPA ID Number: <u>370954745002</u></p> <p>Date of Initial License for Current Owners: <u>02/11/87</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input checked="" type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Rita Armbrust</u> Telephone Number: <u>618 548 0309</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>04/01/99</u> to <u>03/31/00</u> and certify to the best of my knowledge and belief that the said content: are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment</p> <table border="1"> <tr> <td data-bbox="1144 581 1281 735" rowspan="2">Officer or Administrator of Provider</td> <td data-bbox="1281 581 1946 609">(Signed) _____ <u>09/27/00</u> (Date)</td> </tr> <tr> <td data-bbox="1281 609 1946 654">(Type or Print Name) <u>Rita Armbrust</u></td> </tr> <tr> <td data-bbox="1144 654 1281 735"></td> <td data-bbox="1281 654 1946 699">(Title) <u>President</u></td> </tr> <tr> <td data-bbox="1144 735 1281 954" rowspan="4">Paid Preparer</td> <td data-bbox="1281 735 1946 781">(Signed) _____ (Date)</td> </tr> <tr> <td data-bbox="1281 781 1946 842">(Print Name and Title) _____</td> </tr> <tr> <td data-bbox="1281 842 1946 904">(Firm Name & Address) _____</td> </tr> <tr> <td data-bbox="1281 904 1946 954">(Telephone) <u>()</u> Fax # <u>()</u></td> </tr> </table> <p align="right">MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ <u>09/27/00</u> (Date)	(Type or Print Name) <u>Rita Armbrust</u>		(Title) <u>President</u>	Paid Preparer	(Signed) _____ (Date)	(Print Name and Title) _____	(Firm Name & Address) _____	(Telephone) <u>()</u> Fax # <u>()</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																	
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	(Title) <u>President</u>																																		
Paid Preparer	(Signed) _____ (Date)																																		
	(Print Name and Title) _____																																		
	(Firm Name & Address) _____																																		
	(Telephone) <u>()</u> Fax # <u>()</u>																																		

STATE OF ILLINOIS

Page 2

Facility Name & ID Number Reservoir Manor# 0031831 Report Period Beginning: 04/01/99 Ending: 03/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	<u>16</u>	ICF/DD 16 or Less	<u>16</u>	<u>5,840</u>	6
7	<u>16</u>	TOTALS	<u>16</u>	<u>5,840</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	<u>5,503</u>			<u>5,503</u>	13
14	TOTALS	<u>5,503</u>			<u>5,503</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.23%D. How many bed-hold days during this year were paid by Public Aid?
62 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NoneF. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☐ NO ☒H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒I. On what date did you start providing long term care at this location?
Date started 01/01/87J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 01/01/87 NO ☐K. Was the facility certified for Medicare during the reporting year?
YES ☐ NO ☒ If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

MODIFIED
ACCRUAL ☒ CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 03/31/00 Fiscal Year: 03/31/00

* All facilities other than governmental must report on the accrual basis.

Print Preview

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Reservoir Manor # 0031831 Report Period Beginning: 04/01/99 Ending: 03/31/00
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	29,819	2,643	1,033	33,495		33,495	0	33,495		1
2	Food Purchase		34,308		34,308	(1,073)	33,235	0	33,235		2
3	Housekeeping	15,639	4,315		19,954		19,954	0	19,954		3
4	Laundry	2,572	1,248		3,820		3,820	0	3,820		4
5	Heat and Other Utilities			9,412	9,412		9,412	0	9,412		5
6	Maintenance	9,394	6,045	3,806	19,245		19,245	0	19,245		6
7	Other (specify):*							0			7
8	TOTAL General Services	57,424	48,559	14,251	120,234	(1,073)	119,161		119,161		8
	B. Health Care and Programs										
9	Medical Director							0			9
10	Nursing and Medical Records	88,298	886	4,857	94,041	(168)	93,873	0	93,873		10
10a	Therapy							0			10a
11	Activities	16,682	386	420	17,488		17,488	0	17,488		11
12	Social Services	499			499		499	0	499		12
13	Nurse Aide Training	1,760	50	286	2,096		2,096	0	2,096		13
14	Program Transportation			2,245	2,245	(1,120)	1,125	0	1,125		14
15	Other (specify):*							0			15
16	TOTAL Health Care and Programs	107,239	1,322	7,808	116,369	(1,288)	115,081		115,081		16
	C. General Administration										
17	Administrative	53,809			53,809		53,809	0	53,809		17
18	Directors Fees							0			18
19	Professional Services			1,507	1,507		1,507	0	1,507		19
20	Dues, Fees, Subscriptions & Promotions			637	637		637	(47)	590		20
21	Clerical & General Office Expenses	15,819	2,746	2,701	21,266		21,266	0	21,266		21
22	Employee Benefits & Payroll Taxes			56,520	56,520	1,073	57,593	0	57,593		22
23	Inservice Training & Education			397	397	168	565	0	565		23
24	Travel and Seminar			289	289		289	0	289		24
25	Other Admin. Staff Transportation			446	446	276	722	0	722		25
26	Insurance-Prop. Liab. Malpractice			4,285	4,285		4,285	0	4,285		26
27	Other (specify):*							0			27
28	TOTAL General Administration	69,628	2,746	66,782	139,156	1,517	140,673	(47)	140,626		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	234,291	52,627	88,841	375,759	(844)	374,915	(47)	374,868		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification

Print Preview

IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number Reservoir Manor # 0031831 Report Period Beginning: 04/01/99 Ending: 03/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			1,054	1,054		1,054	0	1,054			30
31	Amortization of Pre-Op. & Org.							0				31
32	Interest							0				32
33	Real Estate Taxes			5,107	5,107		5,107	0	5,107			33
34	Rent-Facility & Grounds			54,720	54,720		54,720	0	54,720			34
35	Rent-Equipment & Vehicles							0				35
36	Other (specify):*							0				36
37	TOTAL Ownership			60,881	60,881		60,881		60,881			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					844	844	0	844			38
39	Ancillary Service Centers							0				39
40	Barber and Beauty Shops							0				40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee			31,771	31,771		31,771	0	31,771			42
43	Other (specify):* 1992 Participation Fee			378	378		378	0	378			43
44	TOTAL Special Cost Centers			32,149	32,149	844	32,993		32,993			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	234,291	52,627	181,871	468,789	0	468,789	(47)	468,742			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Print Preview

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number Reservoir Manor # 0031831 STATE OF ILLINOIS Report Period Beginning: 04/01/99 Page 5
Ending: 03/31/00

VI. ADJUSTMENT DETAIL

**A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7
In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(47)	L20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (47)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$ 0		31
32	Donated Goods-Attach Schedule*	0		32
33	Amortization of Organization & Pre-Operating Expense	0		33
34	Adjustments for Related Organization Costs (Schedule VII)	0		34
35	Other- Attach Schedule	0		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (47)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.	x		\$ 844	L14	38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$ 844		47

Print Preview

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Reservoir Manor

0031831 Report Period Beginning:

04/01/99

Ending:

03/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary A

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	0	0	0	0	0	0	0	0	0	0	0	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	0	0	0	0	0	0	0	0	0	0	0	0	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Reservoir Manor

0031831

Report Period Beginning:

04/01/99

Ending:

03/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary B

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	0	0	0	0	0	0	0	0	0	0	0	0	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

Facility Name & ID Number

Reservoir Manor

#

0031831

Report Period Beginning:

04/01/99

Ending:

03/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Rita Armbrust	Fiscal Officer	Administrative	1.00	26,000	16	40.00	Administrati	\$ 15,643	L17 C1	1
2	Dennis Armbrust	Mgmt. Consultant	Administrative	0.00	15,000	20	50.00	Administrative	26,071	L17 C1	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 41,714		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

[Print Preview](#)

Facility Name & ID Number Reservoir Manor# 0031831

Report Period Beginning:

04/01/99Ending: 03/31/00

VIII. ALLOCATION OF INDIRECT COSTS

Show Pgs 8A thru 8D

Show Pgs 8E thru 8I

Hide Pgs 8A thru 8I

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Print Preview

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	7		8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1	None						\$ 0	\$ 0			\$ 0	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						\$	\$			\$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$	\$			\$	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Print Preview

Facility Name & ID Number **Reservoir Manor**# **0031831**

Report Period Beginning:

04/01/99

Ending:

03/31/00**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 1999 report.	\$	5,973	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	1998 \$	4,924	2
3. Under or (over) accrual (line 2 minus line 1).		(1,049)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)		6,156	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$	N/A	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For 19 _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$	N/A	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	5,107	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

1995	4,536	8
1996	4,766	9
1997	4,778	10
1998	4,924	11
1999	5,111	12

The R.E. Taxes accrual for question #4 was estimated as follows:

1998's tax bill x 5/4 = \$4924 x 5/4 = \$6156

	FOR OFF USE ONLY	
13	FROM R. E. TAX STATEMENT FOR 1999	13
14	PLUS APPEAL COST FROM LINE 5	14
15	LESS REFUND FROM LINE 6	15
16	AMOUNT TO USE FOR RATE CALCULATION	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

Print Preview

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 5,375 B. General Construction Type: Exterior Wood & Brick Frame Sprinklered Number of Stories 1

C. Does the Operating Entity? ☐ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☒ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☐ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>N/A</u>			\$	1
2					2
3	TOTALS			\$	3

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE
REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12B

Show Pgs 12C and 12D

Hide Pgs 12A thru 12D

STATE OF ILLINOIS

0031831

Report Period Beginning:

04/01/99 Ending:

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03/31/00

Facility Name & ID Number Reservoir Manor

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	Countertop			1990	588	29	20	29	0	296	9
10	Vinyl Floorcovering			1990	2,044	0	5	0	0	2,044	10
11	Carpet			1987	1,486	0	6	0		1,486	11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				\$ #VALUE!	\$ 29		\$ 29	\$	\$ 3,826	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Facility Name & ID Number Reservoir Manor# 0031831

Report Period Beginning:

04/01/99

Ending:

03/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 11,422	\$ 139	\$ 139	\$ 0	10	\$ 11,422	37
38	Current Year Purchases							38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	\$ 11,422	\$ 139	\$ 139	\$		\$ 11,422	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Transportation of Clients & Staff	1997 Dodge Van	1999	\$ 13,290	\$ 886	\$ 886	\$	4	\$ 886	42
43										43
44										44
45										45
46	TOTALS			\$ 13,290	\$ 886	\$ 886	\$		\$ 886	46

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ #VALUE!	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 1,054	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 1,054	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 16,134	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	None	\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58	None	\$	58
59			59
60			60
61		\$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Print Preview

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Nick Striglos (Jack Woods holds the lease and pays the R.E. Taxes on the Bookkeeping office.

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☒ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>1983</u>	<u>16</u>	<u>01/01/87</u>	\$ <u>54,000</u>	<u>20</u>	<u>0</u>	3
4	Additions							4
5	Office Rent			<u>01/01/87</u>	<u>720</u>	<u>10</u>	<u>0</u>	5
6								6
7	TOTAL		<u>16</u>		\$ <u>54,720</u>			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

0
0

9. Option to Buy: ☐ YES ☒ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☒ YES ☐ NO

16. Rental Amount for movable equipment: \$ N/A Description: Not determinable from Lease Agreement

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>None</u>		\$ <u>0.00</u>	\$ <u> </u>	17
18					18
19					19
20					20
21	TOTAL		\$ <u>None</u>	\$ <u> </u>	21

10. Effective dates of current rental agreement:

Beginning 1/1/87

Ending 12/31/06

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. 03/31/2001 \$ 54,720

13. 03/31/2002 \$ 56,070

14. 03/31/2003 \$ 60,120

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Print Preview

Facility Name & ID Number Reservoir Manor # 0031831 Report Period Beginning: 04/01/99 Ending: 03/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input checked="" type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE <u>50</u>	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input checked="" type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE <u>80</u>
--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

	1	2	3	4
	Facility			
	Drop-outs	Completed	Contract	Total
1 Community College Tuition	\$	\$	\$	\$
2 Books and Supplies		<u>50</u>		50
3 Classroom Wages (a)		<u>600</u>		600
4 Clinical Wages (b)		<u>960</u>		960
5 In-House Trainer Wages (c)		<u>200</u>		200
6 Transportation		<u>286</u>		286
7 Contractual Payments				
8 Nurse Aide Competency Tests				
9 TOTALS	\$	\$ 2,096	\$	\$ 2,096
10 SUM OF line 9, col. 1 and 2 (e)	\$ 2,096			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ None

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	<u>2</u>
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	<u>2</u>

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Print Preview

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

1		2		3		4		5		6		7		8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service	Cost	Units	Cost									
					1	Licensed Occupational Therapist		hrs	\$			\$		\$	
2	Licensed Speech and Language Development Therapist		hrs										2		
3	Licensed Recreational Therapist		hrs										3		
4	Licensed Physical Therapist		hrs										4		
5	Physician Care		visits										5		
6	Dental Care		visits										6		
7	Work Related Program		hrs										7		
8	Habilitation		hrs										8		
9	Pharmacy		# of prescripts										9		
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs										10		
11	Academic Education		hrs										11		
12	Exceptional Care Program												12		
13	Other (specify):												13		
14	TOTAL			\$ 0	0	\$ 0	\$ 0	0	0				14		

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Print Preview

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 93,464		1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	41,853		3
4	Supply Inventory (priced at <u>cost</u>)	2,949		4
5	Short-Term Investments			5
6	Prepaid Insurance	2,078		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	1,030,432		8
9	Other(specify): <u>A/R H.A.Training</u>	2,401		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,173,177	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	4,118		15
16	Equipment, at Historical Cost	24,712		16
17	Accumulated Depreciation (book methods)	(16,134)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 12,696	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,185,873	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 10,928	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	3,644		30
31	Accrued Taxes Payable (excluding real estate taxes)	330		31
32	Accrued Real Estate Taxes(Sch.IX-B)	6,156		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>SEP Contribution to Employee IRA's</u>	36,975		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 58,033	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 58,033	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,127,840	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,185,873	\$	48

*(See instructions.)

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Facility Name & ID Number Reservoir Manor

0031831

Report Period Beginning: 04/01/99

Ending: 03/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,034,850	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,034,850	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	92,990	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 92,990	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,127,840	24 *

* This must agree with page 17, line 47.

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Facility Name & ID Number Reservoir Manor

0031831

Report Period Beginning: 04/01/99

Ending: 03/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 558,482	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 558,482	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 0	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	2,453	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services Transportation	844	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 3,297	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 0	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 0	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 561,779	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	\$ 120,234	31
32	Health Care	116,369	32
33	General Administration	139,156	33
	B. Capital Expense		
34	Ownership	60,881	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	31,771	36
	D. Other Expenses (specify):		
37	1992 Additional Participation Fee Expense	378	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 468,789	40
41	Income before Income Taxes (line 30 minus line 40)**	92,990	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 92,990	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Print Preview

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	51	53	\$ 804	\$ 15.17	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses					4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees	260	260	1,560	6.00	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	986	1,090	8,487	7.79	9
10	Activity Assistants	1,134	1,158	8,195	7.08	10
11	Social Service Workers	50	52	499	9.60	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,033	2,213	17,490	7.90	14
15	Cook Helpers/Assistants	1,578	1,631	12,329	7.56	15
16	Dishwashers					16
17	Maintenance Workers	1,013	1,053	9,394	8.92	17
18	Housekeepers	1,979	2,059	15,639	7.60	18
19	Laundry	366	366	2,572	7.03	19
20	Administrator	382	397	11,981	30.18	20
21	Assistant Administrator					21
22	Other Administrative	1,800	1,872	41,828	22.34	22
23	Office Manager					23
24	Clerical	1,707	1,745	15,819	9.07	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	941	978	17,381	17.77	29
30	Habilitation Aides (DD Homes)	9,492	10,040	70,113	6.98	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) H.A.T. Trainer	25	25	200	8.00	33
34	TOTAL (lines 1 - 33)	23,797	24,992	\$ 234,291 *	\$ 9.37	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	24	\$ 1,033	L1 C3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant		Salaried		38
39	Pharmacist Consultant	24	1,050	L10 C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	24	300	L11 C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	2	143	L10 C3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47	Physician Consultant	17	2,200	L10 C3	47
48	Psychologist Consultant	20	1,290	L10 C3	48
49	TOTAL (lines 35 - 48)	111	\$ 6,016		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	None	\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	None	\$		53

Print Preview

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions				
Name	Function	Ownership %	Amount	Description		Amount	Description		Amount			
Karen Forcum	Administrator	0.00%	\$ 11,981	Workers' Compensation Insurance		\$ 1,220	IDPH License Fee		\$ 200			
Dennis Armbrust	Administrative	0.00%	26,143	Unemployment Compensation Insurance		2,063	Advertising: Employee Recruitment		30			
Rita Armbrust	Administrative	100.00%	15,685	FICA Taxes		16,262	Health Care Worker Background Check (Indicate # of checks performed <u>3</u>)		36			
				Employee Health Insurance			Subscriptions		40			
				Employee Meals		1,073	Vehicle License		84			
				Illinois Municipal Retirement Fund (IMRF)*			DPH Food Service Sanitation Certificate		70			
				SEP/IRA Fund for Employees (See Pg. 21A)		36,975	LNHA License Renewal		100			
							Flowers & Advertising		47			
							Medical Reference Book		30			
							Less: Public Relations Expense		(42)			
							Non-allowable advertising		(5)			
							Yellow page advertising	(
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						\$ 53,809	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 590			
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**				
Description			Amount	Description			Line #	Amount	Description			Amount
None			\$	None				\$	Out-of-State Travel			\$
									None			
									In-State Travel			
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$						11/20/99 Medicine Pass Training--Forcum			50
C. Professional Services									10/12/99 Sanitation Course--Shahini			17
Vendor/Payee	Type	Amount							9/17/99 NHA Seminar--Forcum			42
Krehbiel & Associates	Cost Report Adjustments	\$ 1,465							Seminar Expense			
Shelbyville Daily Union	Non-discriminatory Notice	42							INHAA Trade Show			115
									Diabetes Update @ Lincoln Land College			65
									Entertainment Expense			(
									(agree to Sch. V, line 24, col. 8)			
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 1,507	TOTAL				\$ None	TOTAL			\$ 289

* Attach copy of IMRF notifications

****See instructions.**

Print Preview

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	None		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Print Preview

Facility Name & ID Number Reservoir Manor

0031831

Report Period Beginning:

04/01/99

Ending:

03/31/00

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? No new purchases
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ None Line _____
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation. _____
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over _____
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 31,771
This amount is to be recorded on line 42 of Schedule V. _____
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? Yes If YES, attach an explanation of the allocation. _____
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions _____
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ 1,073 Has any meal income been offset against related costs? N/A No meal ti Indicate the amount. \$ None
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 844
c. What percent of all travel expense relates to transportation of nurses and patients? 66.78%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ None
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

A. Employee Benefits	Line 22	1073	
Food Purchases	Line 2		1073

To reclassify free employee meals from food costs to employee benefits.

B. Other Admn. Staff Trans.	Line 25	276	
Program Transportation	Line 14		276

According to the 15-passenger van mileage log, 11,458 miles were driven this fiscal year (old van: 80,658 less 77,129 plus new van: 3
Of that, 1453 miles were for unloaded errand miles for the facility. Therefore:

L25 Other Admn. Travel = $(1453/11458)(\$980.92 + \$1198.52) = \$276$

C. Inservice Training & Education	Line 23	168	
Nursing & Medical Records	Line 10		168

To reclassify consultants who gave the following inservices during the fiscal year:

R.N. on 4/22/99, 6/22/99, 10/13/99, 1/11/00, 3/20/00, and 3/21/00

D. Medically Necessary Trans.	Line 38	844	
Program Transportation	Line 14		844

To re-classify transportation so that line 38 equals the total accrued medically necessary transportation for this fiscal year.

30,877 less 22,948.)

Line 25 Other Administrative Staff Transportation

Mileage on the 15-passenger van for miles with residents was 1453 miles of the total 11,458 miles driven. Total van costs for gas and i

Mileage for Dennis and Rita Armbrust totalled \$446 from their management office in Salem to Reservoir Manor in Shelbyville.

Van--15 passenger	276
Armbrust	446
Total line 25	722

repairs for the year were \$2179. $[1453 \text{ miles} / 11,458 \text{ miles} \times \$2179 = \$276]$.

VII. Related Parties

*Randolph House:

Rita Armbrust	26,000
Dennis Armbrust	15,000